Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005113	A. BUILDING: _____ B. WING _____	C 06/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSCIUSKO COMMUNITY HOSPITAL	2101 E DUBOIS DR WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one State hospital complaint investigation. Complaint Number: IN00150084 Unsubstantiated; lack of sufficient evidence. Date: 6/30/14 Facility Number: 005113 Surveyor: Linda Plummer, R.N. Public Health Nurse Surveyor Kosciusko Community Hospital is in compliance with 410 IAC 15-1.4-2, Quality assessment and improvement and 410 IAC 15-1.5-2, Infection control, Indiana Hospital Licensure Rules. QA: claughlin 07/08/14	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE